15 April 2015 | CRC FT BLISS, TX MEDICAL PRE-REQUISITES

CRC Ft. Bliss, TX Medical PREREQUISITES – UPDATED March 23, 2015

In order to expedite mobilization, it is recommended that the Ft Bliss SRRC Medical Staff receive all your completed medical forms and documentation at least 14 days in advance of your arrival at CRC Ft Bliss, TX for chart construction. You can scan/e-mail these documents to the following: **usarmy.bliss.medcom-wbamc.mbx.ft-bliss-crc-medical-packet@mail.mil**

QUICK REFERENCE CHECKLIST

References for guidance for Non Log Cap NLC contractors include:

Department of the Army Personnel Policy Guidance for Overseas Contingency Operations and Combatant Command Surgeon Guidance such as CENCOM MOD 12 or CURRENT AFRICOM GUIDANCE and AR 40-501

All DOCUMENTATION MUST BE IN ENGLISH

HISTORY AND PHYSICAL

A physical is required within 90 days of deployment for 1 year deployments (IAW CENTCOM Mod 12, 15.C.1.C) with laboratory testing as needed to determine stability of medical conditions noted will be required.

If pre-deployment physical was performed at a Military Treatment Facility (MTF), use form OF 178 (certification of medical examination) form.

If pre-deployment physical performed by private (civilian) physician, use forms DD 2808 (report of medical examination and DD 2807-1 (report of medical history). (IAW MOD12 15.H.1-2)

A DD Form 2795 must be completed or the previous DD Form 2795 must be confirmed as current within 60 days prior to the expected deployment date. (IAW DODI 6490.03 para E4.A1.1.1.1)

NLC Audiogram Requirements

Please ensure the following items are provided on the completed audiogram all requirements listed are MANDATORY to be considered a valid audiogram

- Full Patient Name, Social, and Date of Birth on document
- **All screening audiograms must be certified by an Audiologist/M.D./D.O. which requires their (Name, Credentials, State of Licensure and number, and signature)** (IAW DODI 6055.12)
- Test date must be visible and within 90 days of Mobilization. (IAW DODI 6055.12 definitions and AR 40-501)
- Test Administrator's name and CAOHC Certification number. Audiologist name and credentials if hand written results on form. If results are on test strip paper, it must be certified by A**udiologist/M.D./D.O.**

- Audiometer Make, Model, Serial Number and calibration date within a year of current audiogram. (IAW DODI 6055.12, AR 40-501 para 2-7, ISO8253:1)
- Audiologist must perform diagnostic audiogram to include air, bone, SRT, speech recognition, tympanometry, SPRINT or HINT if screening audiogram exceeds the following thresholds:

  Audiometer **average level** for each ear at 500, 1000, 2000 Hz not more than 30dB ***or*** not more than 30 dB, with no individual level **greater** than 35 dB at these frequencies, and level not more than 55 dB at 4000 Hz; ***or*** audiometer level 30 dB at 500 Hz, 25 dB at 1000 and 2000 Hz, and 35 dB at 4000 Hz in **better ear**. (Poorer ear may be deaf.) (IAW AR 40-501 Table 7-1)

ALL REQUIREMENTS LISTED ARE MANDATORY TO BE CONSIDERED A VALID AUDIOGRAM

NLC VISION

- Prescription is good for 12 months if signed by a physician (IAW MOD12 15.I.2.A and DoDI 6055.12)
- Visual acuity test within 90 days (IAW AR 40-501 para 11-4h3 and DoDI 6055.12)
- No contact lenses will be worn during medical processing (bring two sets of glasses)
- (I AW DA PAM 40-506 para3-5b and DoDI 6055.12)

NLC DENTAL

- Completed DD Form 2813 (Department of Defense Active Duty/Reserve Forces Dental Examination) (IAW PPG para 7-7a3 and DODI 6490.03 para5.5.11)
- DD Form 2813 must be latest version (OCT 2013) found at http://www.dtic.mil/whs/directives/forms/eforms/dd2813.pdf. All other versions are obsolete.
- Must show you as a Dental Class 1 or 2 {Box 6(1) or 6(2)} and must be signed by dentist (IAW MOD12 15.I.2.G, DODI 6490.03 para5.5.11 & PPG para 7-7a3) Contractors classified in category 3 (box 6(3) a-f) are non-deployable and must have corrective dental action completed and the form completed indicating they are now Dental Readiness Category 1 or 2.
- Must have dentist's state license number (US) (IAW PPG para 7-7a3)
- Bitewing and Panoramic X-rays are required to be reviewed by dentist and Block 6 item (5) of the DD 2813 marked "YES" along with a date that is prior to the exam date.(IAW PPG para 7-7a1 and DODI 6490.03 para5.5.11)

REQUIRED LAB RESULTS

15 April 2015	CRC FT BLISS, TX MEDICAL PRE-REQUISITES

Note results must be typed; handwritten results are not acceptable. Abnormal results may need to be repeated or, if still abnormal, require consultation with appropriate specialist and supporting testing as needed.

- G6PD once in records can be done. Onsite if not completed (IAW MOD12 15.G.3 and DoDI 6024.19 para 6)
- HIV within 120 days of deployment)(IAW MOD12 15.G.1 and DODI 6490.03 para E4.A1.1.7)
- The HIV laboratory test document must be negative, taken within 120 days of deployment date and must be typed, not hand-written.
- Oral HIV testing can NOT be accepted.
- HCG Test "Females" required within 30 days (IAW MOD 12 15.G.4 and PPG para 7-3c1)
- DNA once in records (IAW MOD12 15.G.5 and PPG para 7-3e1 and DoDI 6024.19 para 6)
- Blood Type (IAW MOD12 15.I.2.A and DoDI 6024.19 para 6)
- Lipid Profile within 1 year if age 35 or older (IAW PPG TAB A para B.8 and DoDI 6024.19 para 6)
- EKG within 1 year if age 40 or older (IAW AR 40-501 para 8-26b5 and DoDI 6024.19 para 6)
- PPD (90 days) TB test (IAW MOD12 15.G.6 and DODI 6490.03 para E4.A1.1.4 and DoDI 6024.19 para 6) for **POSITIVE PPD**: must have a COCOM Specific waiver, must have chest X-ray within 90 days. Proof of medication treatment for Latent TB of at least 9 months duration.
- **Lab testing may be required for evaluation of identified medical conditions and may include:**
- Urinalysis within 90 days (IAW AR 40-501 para 3) Results must be typed; they may not be handwritten. Results must show color, specific gravity, glucose, bilirubin, ketones, blood, pH, protein, nitrites, and leukocytes.
- BMP/CHEM 7 within 90 days (IAW AR 40-501 para 3 and DoDI 6024.19 para 6)
- CBC within 90 days (IAW AR 40-501 para3 and DoDI 6024.19 para 6)
- HgA1C within 30 days to demonstrate stability of blood sugar
- Liver Function testing
- Viral load for blood born diseases (such as Hepatitis C or B)

15 April 2015	CRC FT BLISS, TX MEDICAL PRE-REQUISITES

IMMUNIZATIONS

http://www.vaccines.mil/qr/VaccineRecommendations

- Tetanus - TDAP within 10 years (IAW MOD12 15.F.2.A and DODI 6490.03 table E4.T1)
- Varicella – "Chickenpox" 2 shot series vaccine 30 days apart or + titer (IAW MOD12 15.F.2.B and DODI 6490.03 table E4.T1)
- MMR – 2 shot series vaccine or + titer) unless born before 1957 (IAW MOD12 15.F.2.C and DODI 6490.03 table E4.T1)
- Polio - one immunization as an adult (IAW MOD12 15.F.2.D and DODI 6490.03 table E4.T1)
- Influenza (current to this season starts 9/1/2014) (IAW MOD12 15.F.2.A and PPG para 7-6b and DODI 6490.03 table E4.T1)
- Hepatitis A (2 series vaccine)1st and 2nd dose 180 days apart (IAW MOD12 15.F.2.F and DODI 6490.03 table E4.T1)
- Hepatitis B (3 series vaccine)1st and 2nd dose 30 days apart, 3rd dose 6 months after 1st dose (IAW MOD12 15.F.2.G and DODI 6490.03 table E4.T1

HEPATITIS A & B SERIES CAN BE COMPLETED IN THEATER IF UP TO DATE
(IAW PPG para 7-6h)

- Typhoid injection good for 2 years or oral good for 5 years (IAW MOD12 15.F.2.H and DODI 6490.03 table E4.T1)
- Anthrax here at site. This is a 5 shot series and after this you will receive a booster every time you deploy. (IAW MOD12 15.F.3 and DODI 6490.03 table E4.T1)

Other vaccinations may be required per Area of Responsibility requirements.

(See http://www.vaccines.mil/qr/VaccineRecommendations)

TOP REASONS FOR NON-DEPLOYABILITY OR DELAY IN DEPLOYMENT WAIVERS

- Deployees who have a condition, as described in the specific AOR deployment requirements as a "condition generally precluding deployment" must have a complete waiver, signed by the AOR Surgeon's Office. Waivers may be requested prior to travel to CRC and if granted must be available. If waiver has been submitted and approved waiver through CENTCOM or AOR command, you must send the signed waiver to the CRC Medical Staff and hand-carry a copy with you to CRC Ft Bliss, TX.

- Framingham Risk 15% or greater require stress test with imaging

http://cvdrisk.nhlbi.nih.gov

- Documentation for any procedures within the last 90days

BODY MASS INDEX (BMI)

- BMI greater than 40 (link to BMI Calculator: http://www.nhlbi.nih.gov/guidelines/obesity/BMI/bmicalc.htm)
- Greater than 35 with other the following medical co-factors:
  Diabetes, obstructive sleep apnea, heart disease, joint disease; hypertension etc.
- Weight greater than 300 pounds generally will be non deployable

DIABETES

DIABETES TYPE 1 OR 2 ON MEDS WITH HgA1C > 7.0 Use of Insulin or other injected medications. Newly diagnosed diabetics must be demonstrated stable for 90 days and have full evaluation including eye exam foot exam nutrition counseling.

NOTE THIS LIST IS NOT ALL INCLUSIVE – SEE PPG AND SPECIFIC COCOM GUIDANCE

Medical standards for deployment are meant as general guides. The final decision is based on clinical judgment and with Combatant Commander COCOM surgeons office input, which considers the geographical area in which the individual will be assigned and the potential environmental/austere conditions to which they may be subject.
Medical conditions will be reviewed carefully by the SRRC clinician before making a recommendation as to whether the soldier can deploy to duty in a combat zone (or austere isolated area where medical treatment may not be readily available). The authority for waiver of general requirements is the theater surgeon office in whose theater the deploying individual will operate. Based on the COCOM surgeons office understanding of the acceptability of medical conditions and the availability of medications facilities, equipment and possible required medical care in theater where the deploying individual will operate.

DD Form 2807-1

REPORT OF MEDICAL HISTORY
(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

OMB No. 0704-0413
OMB approval expires Aug 31, 2014

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN).
PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services.
ROUTINE USE(S): The Blanket Routine Uses found at http://privacy.defense.gov/blanket_uses.shtml apply to this collection.
DISCLOSURE: Voluntary. However, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYMMDD)

4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)
b. HOME TELEPHONE (Include Area Code)	

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION		
☐ Army ☐ Coast Guard	☐ Regular	☐ Enlistment	☐ Medical Board	☐ Other (Specify)
☐ Navy	☐ Reserve	☐ Commission	☐ Retirement	
☐ Marine Corps	☐ National Guard	☐ Retention	☐ U.S. Service Academy	
☐ Air Force		☐ Separation	☐ ROTC Scholarship Program	

7.a. POSITION (Title, Grade, Component)	8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
b. USUAL OCCUPATION		

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
10.a. Tuberculosis	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11.a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss of vision in either eye	○	○
f. Worn contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	○	○
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○
12. (Continued)	YES	NO
f. Foot trouble (e.g., pain, corns, bunions, etc.)	○	○
g. Impaired use of arms, legs, hands, or feet	○	○
h. Swollen or painful joint(s)	○	○
i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	○	○
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
l. Bone, joint, or other deformity	○	○
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
n. Broken bone(s) (cracked or fractured)	○	○
13.a. Frequent indigestion or heartburn	○	○
b. Stomach, liver, intestinal trouble, or ulcer	○	○
c. Gall bladder trouble or gallstones	○	○
d. Jaundice or hepatitis (liver disease)	○	○
e. Rupture/hernia	○	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	○
g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	○	○
h. Frequent or painful urination	○	○
i. High or low blood sugar	○	○
j. Kidney stone or blood in urine	○	○
k. Sugar or protein in urine	○	○
l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	○	○
14.a. Adverse reaction to serum, food, insect stings or medicine	○	○
b. Recent unexplained gain or loss of weight	○	○
c. Currently in good health (If no, explain in Item 29 on Page 2.)	○	○
d. Tumor, growth, cyst, or cancer	○	○

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
15.a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions, epilepsy or fits	○	○
f. Car, train, sea, or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
16.a. Rheumatic fever	○	○
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17.a. Nervous trouble of any sort *(anxiety or panic attacks)*	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. **FEMALES ONLY.** Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons *(If yes, give reasons.)*	○	○
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	○	○
21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*	○	○
22. Have you ever had, or have you been advised to have any operations or surgery? *(If yes, describe and give age at which occurred.)*	○	○
23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	○	○
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	○	○
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	○	○
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	○	○
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*	○	○
28. Have you ever been denied life insurance?	○	○

29. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)*

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

DD Form 2808

REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)	5. HOME TELEPHONE NUMBER (Include Area Code)

6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX	10.a. RACIAL CATEGORY (X one or more)	b. ETHNIC CATEGORY
			☐ Female ☐ Male	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic/Latino ☐ Not Hispanic/Latino

11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY	b. CIVILIAN	12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE

14.a. RATING OR SPECIALTY (Aviators Only)	b. TOTAL FLYING TIME	c. LAST SIX MONTHS

15.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code)
☐ Army ☐ Coast Guard ☐ Navy ☐ Marine Corps ☐ Air Force	☐ Active Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☐ Commission ☐ Retention ☐ Separation ☐ Medical Board ☐ Other ☐ Retirement ☐ U.S. Service Academy ☐ ROTC Scholarship Program	

CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnormal	NE
17. Head, face, neck, and scalp			
18. Nose			
19. Sinuses			
20. Mouth and throat			
21. Ears - General *(Int. and ext. canals/Auditory acuity under item 71)*			
22. Drums *(Perforation)*			
23. Eyes - General *(Visual acuity and refraction under items 61 - 63)*			
24. Ophthalmoscopic			
25. Pupils *(Equality and reaction)*			
26. Ocular motility *(Associated parallel movements, nystagmus)*			
27. Heart *(Thrust, size, rhythm, sounds)*			
28. Lungs and chest *(Include breasts)*			
29. Vascular system *(Varicosities, etc.)*			
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*			
31. Abdomen and viscera *(Include hernia)*			
32. External genitalia *(Genitourinary)*			
33. Upper extremities			
34. Lower extremities *(Except feet)*			
35. Feet *(See item 35 Continued)*			
36. Spine, other musculoskeletal			
37. Identifying body marks, scars, tattoos			
38. Skin, lymphatics			
39. Neurologic			
40. Psychiatric *(Specify any personality deviation)*			
41. Pelvic *(Females only)*			
42. Endocrine			

44. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in item 44.)*
☐ Acceptable
☐ Not Acceptable Class _____

35. FEET *(Continued) (Circle category)*
Normal Arch — Mild — Asymptomatic
Pes Cavus — Moderate
Pes Planus — Severe — Symptomatic

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)				SOCIAL SECURITY NUMBER
LABORATORY FINDINGS				
45. URINALYSIS	a. Albumin b. Sugar	46. URINE HCG	47. H/H	48. BLOOD TYPE

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV			
50. DRUGS			
51. ALCOHOL			
52. OTHER			
a. PAP SMEAR			
b.			
c.			

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT lbs.	55. MIN WGT - MAX WGT MAX BF %	56. TEMPERATURE	57. PULSE

58. BLOOD PRESSURE			59. RED/GREEN *(Army Only)*	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD		
SYS.	SYS.	SYS.		
DIAS.	DIAS.	DIAS.		

61. DISTANT VISION		62. REFRACTION BY AUTOREFRACTION OR MANIFEST			63. NEAR VISION		
Right 20/	Corr. to 20/	By	S.	CX	Right 20/	Corr. to 20/	by
Left 20/	Corr. to 20/	By	S.	CX	Left 20/	Corr. to 20/	by

64. HETEROPHORIA *(Specify distance)*

ES° EX° R.H. L.H. Prism div. Prism Conv CT NPR PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*		67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right	Left	PIP	/14	Uncorrected	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
		O.D.	O.S.

71a. AUDIOMETER	Unit Serial Number						71b. Unit Serial Number							72a. READING ALOUD TEST
Date Calibrated *(YYYYMMDD)*							Date Calibrated *(YYYYMMDD)*							☐ SAT ☐ UNSAT
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	
Right							Right							72b. VALSALVA
Left							Left							☐ SAT ☐ UNSAT

73. NOTES *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY** *(Use additional sheets if necessary.)*

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

74.a. EXAMINEE/APPLICANT *(check one)*	75. I have been advised of my disqualifying condition.	
☐ IS QUALIFIED FOR SERVICE ☐ IS NOT QUALIFIED FOR SERVICE	a. SIGNATURE OF EXAMINEE	b. DATE *(YYYYMMDD)*

b. PHYSICAL PROFILE

P	U	L	H	E	S	X	PROFILER INITIALS	DATE *(YYYYMMDD)*

76. SIGNIFICANT OR DISQUALIFYING DEFECTS

ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALIFIED	DISQUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

77. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary.)*

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify) (Use additional sheets if necessary.)*

79. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIAL	WKID	ST	DATE *(YYYYMMDD)*	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	b. SIGNATURE
84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY	b. SIGNATURE

85. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE *(YYYYMMDD)*

86. WAIVER GRANTED *(If yes, state and by whom)*	87. NUMBER OF ATTACHED SHEETS
☐ YES ☐ NO	

DD FORM 2808, OCT 2005

DD Form 2813

DEPARTMENT OF DEFENSE
ACTIVE DUTY/RESERVE/GUARD/CIVILIAN FORCES DENTAL EXAMINATION

OMB No. 0720-0022
OMB approval expires Aug 31, 2016

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136; 10 U.S.C. 1074f; DoD Directives 1404.10, 5101.1, 5136.01, and 6490.02E; DoD Instruction 6025.19; and E.O. 9397 (SSN), as amended.
PRINCIPAL PURPOSE(S): To obtain information in order to record an assessment of an individual's dental health.
ROUTINE USE(S): Information collected may be used and disclosed generally as permitted under 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules, as implemented by DoD 6025.18-R, the DoD Health Information Privacy Regulation. Information may also be used and disclosed in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD "Blanket Routine Uses" published at http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html. Information from this system may be shared with other Federal and State agencies and civilian health care providers, as necessary, to provide medical care and treatment and to guide possible referrals.
DISCLOSURE: Voluntary; however, failure to provide the information may result in delays in assessing your dental health needs for military service and/or for possible deployment outside the United States and its territories and possessions.

1. SERVICE MEMBER'S NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NUMBER	3. BRANCH OF SERVICE

4. UNIT OF ASSIGNMENT	5. UNIT ADDRESS

6. EXAMINATION RESULTS

Dear Doctor,

The individual you are examining is an Active Duty/Guard/Reserve/Civilian member of the United States Armed Forces. This member needs your assessment of his/her dental health for worldwide duty. **Please mark (X) the block** that best describes the condition of the member, using as a suggested minimum a clinical examination with mirror and probe, and bitewing radiographs. **This form is meant to determine fitness for prolonged duty without ready access to dental care and is not intended to address the member's comprehensive dental needs.**

	(1) Patient has good oral health and is not expected to require dental treatment or reevaluation for 12 months.
	(2) Patient has some oral conditions, but you **do not** expect these conditions to result in dental emergencies within 12 months if not treated (i.e., requires prophylaxis, asymptomatic caries with minimal extension into dentin, edentulous areas not requiring immediate prosthetic treatment).
	(3) Patient has oral conditions that you **do** expect to result in dental emergencies within 12 months if not treated. Examples of such conditions are: *(X the applicable block or specify in the space provided)*
	(a) **Infections:** Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.
	(b) **Caries/Restorations:** Dental caries or fractures with moderate or advanced extension into dentin; defective restorations or temporary restorations that patients cannot maintain for 12 months.
	(c) **Missing Teeth:** Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communication, or acceptable esthetics.
	(d) **Periodontal Conditions:** Acute gingivitis or pericoronitis, active moderate to advanced periodontitis, periodontal abscess, progressive mucogingival condition, moderate to heavy subgingival calculus, or periodontal manifestations of systemic disease or hormonal disturbances.
	(e) **Oral Surgery:** Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
	(f) **Other:** Temporomandibular disorders or myofascial pain dysfunction requiring active treatment.

(4) If you selected Block (3) above, please indicate the condition(s) you identified in this patient if they appear above, or briefly describe the condition(s) below:

(5) Were X-rays consulted?		YES		NO	IF YES, DATE X-RAY WAS TAKEN *(YYYYMMDD)*

7. DENTIST'S NAME *(Last, First, Middle Initial)*	8. DENTIST'S ADDRESS *(Street, City, State, 9-digit ZIP Code)*
9. DENTIST'S TELEPHONE NUMBER *(Include Area Code)*	

10. DENTIST'S SIGNATURE/STATE LICENSE NUMBER	11. DATE OF EXAMINATION *(YYYYMMDD)*

DD FORM 2813, OCT 2013 PREVIOUS EDITION IS OBSOLETE. Adobe Professional X

DD Form 2215

REFERENCE AUDIOGRAM

(This form is subject to the Privacy Act of 1974 - use Blanket PAS - DD Form 2005)

1. ZIP CODE/APO/FPO/PAS

2. DOD COMPONENT
A - ARMY F - AIR FORCE 1 - OTHER
N - NAVY M - MARINE CORPS

3. SERVICE COMPONENT
R - REGULAR G - NATIONAL GUARD
V - RESERVE 1 - OTHER

4. SOCIAL SECURITY NUMBER

5. NAME *(Last, First, Middle Initial)*

6. DATE OF BIRTH *(YYYYMMDD)*

7. SEX
M - MALE
F - FEMALE

8. PAY GRADE, UNIFORMED SERVICES

9. PAY GRADE, CIVILIAN

10. SERVICE DUTY OCCUPATION CODE

11. MAILING ADDRESS OF ASSIGNMENT

12. LOCATION - PLACE OF WORK

13. MAJOR COMMAND

14. DUTY TELEPHONE *(Include area code)*

AUDIOMETRY

15. REASON FOR CONDUCTING AUDIOGRAM
1 - REFERENCE ESTABLISHED PRIOR TO INITIAL DUTY IN HAZARDOUS NOISE AREAS
2 - REFERENCE ESTABLISHED FOLLOWING EXPOSURE IN NOISE DUTIES
3 - REFERENCE RE-ESTABLISHED AFTER FOLLOW-UP PROGRAM

16. AUDIOMETRIC DATA RE: ANSI S3.6 - 1989	LEFT						RIGHT					
	500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
17. DATE OF AUDIOGRAM *(YYYYMMDD)*												

18. MEETS REFERRAL CRITERIA
1 - NO
2 - YES

19. MILITARY TIME OF DAY *(Optional)*

20. HOURS SINCE LAST NOISE EXPOSURE

21. EAR, NOSE, AND THROAT PROBLEM AT TIME OF TEST
1 - NO 2 - YES 3 - UNKNOWN

22. EXAMINER

a. NAME *(Last, First, Middle Initial)*

b. TRAINING CERTIFICATION NUMBER

c. SERVICE DUTY OCCUPATION CODE

d. OFFICE SYMBOL

23. AUDIOMETER

a. TYPE
1 - MANUAL
2 - SELF-RECORDING *(Automatic)*
3 - MICROPROCESSOR

b. MODEL

c. MANUFACTURER

d. SERIAL NUMBER

e. LAST ELECTROACOUSTIC CALIBRATION DATE *(YYYYMMDD)*

24. PERSONAL HEARING PROTECTION

a. TYPE ISSUED
1 - SINGLE FLANGE (VS1R)
2 - TRIPLE FLANGE
3 - HAND FORMED EARPLUG
4 - EAR CANAL CAPS
5- NOISE MUFFS
6 - OTHER
7 - NONE

b. SIZE EARPLUGS
L R
1 - XS 4 - L
2 - S 5 - XL
3 - M

c. DOUBLE PROTECTION USED
1 - NO
2 - YES

d. GLASSES WORN *(Including goggles)*
1 - NO
2 - YES

e. FREQUENCY GLASSES WORN
1 - ALWAYS
2 - SELDOM
3 - N/A

25. REMARKS *(Include exposure data)*

DD FORM 2215, JAN 2000 PREVIOUS EDITION MAY BE USED. Adobe Professional 7.0

INSTRUCTIONS

(Refer to DoD Component Instructions for additional guidance)

PURPOSE: This form is used to record initial audiometric test results with which later audiometric test results can be compared (see DD Form 2216, "Hearing Conservation Data," to record periodic test results).

1. ZIP CODE/APO/FPO/PAS. Enter nine digit ZIP Code/APO/FPO/ PAS of where audiometric test is conducted.

2. DOD COMPONENT. Enter letter in box of major organizational subdivision of DoD to which military or civilian individual is assigned. Enter "1" if DoD component is not listed.

3. SERVICE COMPONENT. Enter letter in box corresponding to primary subdivision of separate military service in which military is assigned (e.g., Regular (R) - standing military component of armed forces in peace and war; Reserve (V) - component of ready trained personnel for military service when needed, etc.; National Guard (G) - component of National Guard personnel in full-time or part-time status). Enter "1" for all others, including civilians.

PERSONAL DATA OF INDIVIDUAL BEING TESTED:

4. SOCIAL SECURITY NUMBER. Enter nine digit social security number. If foreign national, enter "FN" in middle two blocks.

5. NAME. Enter surname, given name and middle initial.

6. DATE OF BIRTH. Enter year, month, day.

7. SEX. Enter "M" if male, "F" if female.

8. PAY GRADE, UNIFORMED SERVICES. For military personnel only, enter military personnel class and pay level serial number as follows:

- O11 - General of the Army/General of the Air Force/Fleet Admiral
- O10 - General/Admiral
- O09 - Lieutenant General/Vice Admiral
- O08 - Major General/Rear Admiral (Upper Half)
- O07 - Brigadier General/Rear Admiral (Lower Half)/Commodore
- O06 - Colonel (A,F,M)/Captain (N)
- O05 - Lieutenant Colonel/Commander
- O04 - Major/Lieutenant Commander
- O03 - Captain (A,F,M)/Lieutenant (N)
- O02 - First Lieutenant/Lieutenant Junior Grade
- O01 - Second Lieutenant/Ensign
- W05 - Chief Warrant Officer, W-5
- W04 - Chief Warrant Officer, W-4
- W03 - Chief Warrant Officer, W-3
- W02 - Chief Warrant Officer, W-2
- W01 - Warrant Officer, W-1
- C00 - Cadet/Midshipman
- E09 - Sergeant Major/Chief Master Sergeant/Master Chief Petty Officer
- E08 - Master Sergeant (A,M)/Senior Chief Petty Officer/Senior Master Sergeant/First Sergeant(A)
- E07 - Sergeant First Class/Gunnery Sergeant/Chief Petty Officer/ Master Sergeant (F)/Platoon Sergeant (A)/Specialist-7
- E06 - Staff Sergeant/Technical Sergeant/Petty Officer First Class/ Specialist-6
- E05 - Sergeant (A,M)/Staff Sergeant/Petty Officer Second Class/ Specialist-5
- E04 - Corporal/Sergeant (F)/Petty Officer Third Class/Specialist-4
- E03 - Private First Class (A)/Airman First Class/Lance Corporal/Seaman
- E02 - Private (PV1)/Airman/Private First Class (M)/Seaman Apprentice
- E01 - Private (PV2)/Private (M)/Airman Basic/Seaman Recruit

9. GRADE, CIVILIAN. Enter two letters and two numbers of Federal civilian employee rank (e.g., WG05, GS11, etc.). Letter entries will be WG, WL, WS, WN, WD or GS. Number entries will be 01 to 18. Enter "1111" if other (e.g., foreign national, contractor, etc.).

10. SERVICE DUTY OCCUPATION CODE. Enter code to which military member's duty occupation is assigned (e.g., MOS, SSI, NEC/Rating, NOBC or AFSC in which individual is actually working). Enter number code of civilian job series in which civilian member is actually working (e.g., for a carpenter enter "4607").

11. MAILING ADDRESS OF ASSIGNMENT. Enter installation name (and street address for Navy and Marines), unit, office symbol, and ZIP Code/APO/FPO/PAS of individual's current duty assignment.

12. LOCATION - PLACE OF WORK. Enter specific location where individual is routinely exposed to hazardous noise including building number (e.g., Corpus Christi, NAS, Building 1571, Carpenter Shop). For Air Force personnel, enter 12-digit Workplace Identifier Code per AFOSH Std. 161-17.

13. MAJOR COMMAND. Enter authorized abbreviation of military major command to which individual is assigned.

14. DUTY TELEPHONE. Enter individual's duty telephone number.

AUDIOMETRY:

15. REASON FOR CONDUCTING AUDIOGRAM. Enter number in box for reason to complete reference audiogram.

1 - Individual has not yet worked in hazardous noise duty areas and no reference audiogram has been accomplished.

2 - Individual has worked in hazardous noise duty areas but reference audiogram has been lost or was never accomplished.

3 - Individual has worked in hazardous noise duty areas and requires revised reference audiogram following completion of hearing conservation follow-up program.

16. AUDIOMETRIC DATA RE: ANSI S3.6 - 1989. Enter threshold levels determined for this individual at six frequencies in each ear. Results are entered in 5dB increments (e.g., 0, 5, 10, 15, etc). If responses exceed maximum limits of audiometer, enter that limit with plus sign (e.g., 110 +).

17. DATE OF AUDIOGRAM. Enter year, month, and day the audiometric test is given. (If January 14, 1999, enter 19990114.)

18. MEETS REFERRAL CRITERIA. Based on the audiometric test results, each DoD component should apply its own criteria.

19. MILITARY TIME OF DAY. Enter four digits for hour of day (24-hour clock) this audiogram is completed (e.g., "0830," "1400," etc.). This field is optional.

20. HOURS SINCE LAST NOISE EXPOSURE. Enter appropriate number of hours prior to this audiogram that individual was last exposed to hazardous noise (e.g., steady noise 85 dBA or greater and/or impulse noise above 140 dBP).

21. EAR, NOSE, AND THROAT PROBLEM AT TIME OF TEST. Enter "1" (NO) if individual has no ear, nose or throat problems at time of test that could be causing a temporary (conductive) hearing loss (e.g., ear canal blocked with ear wax, ear infection, head cold, etc.). Enter "2" (YES) if problem was present and "3" (UNKNOWN) if no way to determine presence of problem.

22. EXAMINER.

a. Name. Enter surname, given name and middle initial of individual operating audiometer.

b. Training Certification Number. Enter audiometric technician training certification number.

c. Service Duty Occupation Code. Enter examiner's service duty occupation code (see Item 10).

d. Office Symbol. Enter complete office symbol where examiner is performing the test.

23. AUDIOMETER.

a. Type. Enter number for type of audiometer used (e.g., "1" for manual type).

b. Model. Enter manufacturer's designation.

c. Manufacturer. Enter name of company that produced audiometer.

d. Serial Number. Enter manufacturer's serial number.

e. Last Electroacoustic Calibration Date. Enter year, month and day (see Item 16) of last electroacoustic determination of this audiometer's performance specifications.

24. PERSONAL HEARING PROTECTION.

a. Type Issued. Enter number for type of hearing protector that the individual was issued (e.g., "2" for triple flange, etc.; if "6 - OTHER," explain in Item 25, "Remarks").

b. Size Earplugs. Enter number for size of earplugs (single or triple flange) used for each ear (e.g., "4" for Large in right ear (R) and "3" for Medium or Regular in left ear (L)).

c. Double Protection Used. Enter "1" in box if earplugs are not routinely worn in combination with noise muffs or a noise-attenuating helmet. Enter "2" if they are routinely worn together.

d. Glasses Worn. Enter "1" in box if eye glasses or goggles are not routinely worn with noise muffs or noise-attenuating helmet.

e. Frequency Glasses Worn. Indicate frequency of use if "2" was entered in Item 24.d. If "1" was entered in 24.d., enter "3" - N/A.

25. REMARKS. Print explanations for any of above items marked "OTHER" and any information considered pertinent. Include the individual's 8-hour TWA noise exposure, when available.

DD FORM 2215 (BACK), JAN 2000